STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155742	A. BUILDING 00 B. WING	05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS HEALTH CAMPUS	1400 LAMMERS PIKE BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Recertification and State Licensure Survey. Survey dates: May 23, 24, 25, 26, and 27, 2011 Facility number: 004671 Provider number: 155742 AIM number: 200538760 Survey team: Penny Marlatt, RN, TC Diana Sidell, RN Janie Faulkner, RN (May 24, 25, 26, and 27, 2011) Barbara Gray, RN (May 25, 26, 27, 2011) Census bed type: SNF: 5 SNF/NF: 43 Residential: 32 Total: 80 Census payor type: Medicare: 8	F0000	R117 Personnel1. Staff; CNA's #1, 2, 3, 4, 7, LPN #5 QMA #6 and the Activity Director will be trained on First Aid by July 1, 2011.2. all other staff that are scheduled on Residental Files were reviewed to assure current first aid by the Director of Health Services/Designee by July 1, 2011.3. All Depart Leaders to Include Payroll were inserviced on the policy on First aid training by Director of Health Services/Designee by July 1, 2011.4. Director of Health Services or Designee will monitor all employee files that work Residental to assure continuing education in first aid. These audits will be ongoing. All results will be reviewed by the QA committee to assure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicaid: 19 Other: 53 Total: 80 Sample: 12 Supplemental sample: 2 Residential sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/6/11 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician for a continuation of a previous order for supplemental oxygen therapy for 1 of 12 residents reviewed for oxygen therapy. (Resident #20) Findings include:	F0157	F157 Notify of Changes1. Resident #20 oxygen has been discontinuted.2. All residents receiving oxygen's clinical record will be reviewed by DHS or designee to assure current physcian orders by July 1, 2011.3. Nurses have been re-inserviced on admission process with emphasis on physician orders by	07/01/2011

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	Resident #20's clinical record was reviewed on 5-26-11 at 10:30 a.m. Her diagnoses included, but were not limited to left lower lobe pneumonia (March 2011), diabetes mellitus, hypertension (high blood pressure), osteoarthritis, chronic kidney disease and coronary artery disease. Records indicated Resident #20 had been hospitalized at an area hospital 3-23-2011 until 3-28-2011 with the above noted left lower lobe pneumonia. The clinical record indicated upon return to the facility on 3-28-2011, there was no documentation of a current physician's order for oxygen therapy. Nursing notes documented the use of oxygen with the readmission assessment on 3-28-11 at 2330 (11:30 p.m.) with the oxygen at 2 LPM (liters per minute) via a nasal cannula with the oxygen saturation rate at 93%. Nursing assessments on 3-29-11 at 1:15 a.m., 3:00 a.m., 9:10 a.m. and 11:20 p.m., on 3-30-11 at 12:15 p.m., on 3-31-11 at 1:00 p.m. and on the 2:00 p.m. to 10:00 p.m. shift (no specific time indicated) and on 4-4-11 at 5:50 a.m. Each assessment listed indicated the oxygen was at 2 LPM. In interview with the Director of Health Services (DHS) on 5-26-11 at 12:02 p.m.,		DHS/designee by July 1, 2011.4. All admit/readmit records shall be reviewed by DHS or designee during CQI meetings for accuracy of orders. This audit is ongoing.	

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	she indicated that any time a resident is kept in the hospital for more than 24 hours that the facility always gets all new physician orders for that resident upon return to the facility. In interview with the DHS on 5-26-11 at 12:30 p.m., she indicated the facility had been unable to locate any orders for (supplemental) oxygen after she returned from the hospital (in March 2011.) She indicated the resident had (physician) orders for oxygen prior to her hospitalization. 3.1-5(a)(3)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to ensure all allegations of abuse or misappropriation of resident property were reported to the State Survey and Certification Agency in that one	F0225	F225 Investigate/Report Allegations/Individuals1. Residents #21, #44, & # 45 Allegations have been reviewed by state Agency on 5/25/112. All other concern forms have been	07/01/2011

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	incident of staff to resident roughness and four incidences of missing property were not reported. This affected 2 of 3 residents reviewed for abuse and misappropriation of property in a sample of 12 and 1 of 2 residents in a supplemental sample of 2. (Residents #21, #44, and #45) Findings include: An "Abuse Policy", with a last review date of 12/29/10, was provided by the Social Services Director on 5/25/11 at 10:15 a.m. The policy included, but was not limited to, "Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect....DEFINITIONS...Physical Abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc...Misappropriation of Property - includes, but is not limited to, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds...6. Investigation / Reporting - the Executive Director and Director of Health Services are accountable for investigating and reporting. a. Refer to the Incident and Accident Program for investigation procedures...."		reviewed by Executive Director to assure anyother allegations have been reported as per regulation by July 1, 2011.3. Executive Director, Director of Health Services, Social Services and all other Department Leaders have been re-inserviced on the Policy related to reporting of all allegations to state agency and APS by clinical support/designee by July 1, 2011.4. All concern forms will be reviewed by Executive Director/designee to assure compliance. Audits will continue until 100% compliance is reached times three consecutive months. All results will be reviewed by QA committee and need for further auditing will be determined by the committee.	

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A policy for "Accidents and Incidents; Reports, Investigations, Follow-up and Disposition", with a last review date of 12/29/10, was provided by Employee #9/Medical Records on 5/23/11 at 2:58 p.m. The policy indicated, but was not limited to, "...2. To assure that the definition of accident/incidents may include, but are not limited to the following...Abuse or suspected abuse...PROCEDURE: 1. Should an accident/incident occur, THS strives to prevent repeated occurrences. A thorough investigation and follow-up will be completed within five days, as indicated...Occurrences where there is suspected mistreatment, neglect, abuse, or injuries of unknown origin will be immediately reported to the Director of Health Services and Executive Director. Reports to other officials/agencies will be made in accordance with State Law...."

A policy for "Prevention and Reporting of Suspected Resident Abuse and Neglect", with a last review date of 12/29/10, was provided by Employee #9/Medical Records on 5/23/11 at 2:58 p.m. The policy included, but was not limited to, "...b. 24 hour initial reporting to applicable state agencies...d. A written report of the investigation outcome, including resident response and/or

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	condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days...." 1. Resident # 21's record was reviewed on 5/27/11 at 4:20 p.m. The record indicated Resident #21 was admitted with diagnoses that included, but were not limited to, arthritis, osteoporosis, left hip pain, and increased weakness. An admission Minimum Data Set (MDS) Assessment dated 9/22/11 indicated Resident #21 had no cognitive impairment and no long term or short term memory problems. A "Resident Concern Form" dated 2/23/11 indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception...."			

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An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech [mechanical] lift. Resident felt that personnal (sic) needs were not ment." (sic) This form was documented as a verbal warning for the type of disciplinary action.

During an interview on 5/27/11 at 10:15 a.m., the Social Services Director indicated this incident had not been reported to the Indiana State Department of Health.

2. Resident #44's record was reviewed on 5/25/11 at 3:52 p.m. The record indicated Resident #45 was admitted with diagnoses that included, but were not limited to, high blood pressure, stroke, diabetes mellitus, arthritis, and osteoporosis.

A quarterly MDS assessment dated 3/30/11 indicated Resident #44 was moderately cognitively impaired and had short term and long term memory problems.

A "Resident Concern Form" dated 11/8/10 indicated a concern of lost money, "$60

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missing over last several weeks." This incident was investigated and family notified.

A "Resident Concern Form" dated 5/10/11 at 4:40 p.m. indicated a concern of lost property: "4 - $100 bills, check for $100." This incident was investigated and family notified.

During an interview on 5/27/11 at 3:18 p.m., the Executive Director indicated these incidents had not been reported to the Indiana State Department of Health. She said: "If I knew for sure the money was missing I would report to ISDH for misappropriation of funds. With him I'm not sure that he actually has money missing."

3. Resident #45's record was reviewed on 5/27/11 at 8:55 a.m. The record indicated Resident #45 was admitted with diagnoses that included, but were not limited to, anemia, degenerative joint disease, osteoarthritis, and insomnia.

A quarterly MDS assessment dated 3/24/11 indicated Resident #45 had no cognitive impairment and no long or short term memory problems.

A "Resident Concern Form" dated 11/8/10

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	at 11:01 (no a.m. or p.m. on the form) was provided by the Social Services Director on 5/27/11 at 10:15 a.m. and indicated a concern of lost property, a Samsung LCD 18 inch TV. The investigation included: "Interviewed all staff - reports they recall seeing it but assumed fam. took hm (home) when brought in her 52" TV. Nurse [name of nurse] reported [Resident] mentioned giving it to a friend at [another facility]. TC (telephone call) made to [another facility]. Friend - [name] did not have TV per TC (telephone) call. Searched all res[ident] rooms storage of items for facility - not located. Spoke [with] res[ident] & fam[ily]. They are satisfied [with] investigation. No resolution." A "Resident Concern Form" dated 12/30/10 at 11:00 a.m. indicated a concern of lost property; "$45 worth of #5 bills in an envelop in a shoe box on her bed - was out of Rm for 1 - 1 1/2 hr 12/29 afternoon." This incident was investigated and police and family were notified. During an interview on 5/27/11 at 10:15 a.m., the Social Services Director indicated these two incidents had not been reported to the Indiana State Department of Health.			

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	3.1-28(a)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement the abuse policy and procedures related to reporting alleged occurrences of abuse or misappropriation of residents property to the State Agency in that one incident of staff to resident roughness and four incidences of missing property were not reported. This affected 2 of 3 residents reviewed for implementation of the abuse policies in a sample of 12 and 1 of 2 residents in a supplemental sample of 2. (Residents #21, #44, and #45) Findings include: An "Abuse Policy", with a last review date of 12/29/10, was provided by the Social Services Director on 5/25/11 at 10:15 a.m. The policy included, but was not limited to, "Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to	F0226	F226 Development/Implement Abuse/Neglect, etc. policies1. Resident #21, #44 & #45 allegations have been reviewed by state agency on May 25, 2011.2. All other concern forms have been reviewed by the Exective Director to assure any other allegations have been reported as per regulation by July 1, 20113. Executive Director, Director of Health Services and all other department leaders have been re-inserviced on policy related to reporting of all allegations to state agency and APS by clinical support/designee by July 1, 2011.4. All concern forms will be reviewed by the Executive Director/Designee to assure compliance. Audits will continue until 100% compliance is reached times three consecutive months. All results willl be reviewed by QA committee and need for further auditing will be determined by committee.	07/01/2011

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	ensure the prevention and reporting of suspected or alleged resident abuse and neglect....DEFINITIONS...Physical Abuse - includes hitting, slapping, pinching, spitting, holding or handling roughly, etc...Misappropriation of Property - includes, but is not limited to, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds...6. Investigation / Reporting - the Executive Director and Director of Health Services are accountable for investigating and reporting. a. Refer to the Incident and Accident Program for investigation procedures...." A policy for "Accidents and Incidents; Reports, Investigations, Follow-up and Disposition", with a last review date of 12/29/10, was provided by Employee #9/Medical Records on 5/23/11 at 2:58 p.m. The policy indicated, but was not limited to, "...2. To assure that the definition of accident/incidents may include, but are not limited to the following...Abuse or suspected abuse...PROCEDURE: 1. Should an accident/incident occur, THS strives to prevent repeated occurrences. A thorough investigation and follow-up will be completed within five days, as indicated...Occurrences where there is suspected mistreatment, neglect, abuse, or			

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	injuries of unknown origin will be immediately reported to the Director of Health Services and Executive Director. Reports to other officials/agencies will be made in accordance with State Law...." A policy for "Prevention and Reporting of Suspected Resident Abuse and Neglect", with a last review date of 12/29/10, was provided by Employee #9/Medical Records on 5/23/11 at 2:58 p.m. The policy included, but was not limited to, "...b. 24 hour initial reporting to applicable state agencies...d. A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days...." 1. Resident # 21's record was reviewed on 5/27/11 at 4:20 p.m. The record indicated Resident #21 was admitted with diagnoses that included, but were not limited to, arthritis, osteoporosis, left hip pain, and increased weakness. An admission Minimum Data Set (MDS) Assessment dated 9/22/11 indicated Resident #21 had no cognitive impairment and no long term or short term memory problems.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A "Resident Concern Form" dated 2/23/11 indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception...." An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment." (sic) This form was documented as a verbal warning for the type of disciplinary action. During an interview on 5/27/11 at 10:15 a.m., the Social Service Director indicated that this incident had not been reported to the Indiana State Department of Health. 2. Resident #44's record was reviewed on			

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	155742	A. BUILDING 00 B. WING	05/27/2011

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	5/25/11 at 3:52 p.m. The record indicated Resident #45 was admitted with diagnoses that included, but were not limited to, high blood pressure, stroke, diabetes mellitus, arthritis, and osteoporosis. A quarterly MDS assessment dated 3/30/11 indicated Resident #44 was moderately cognitively impaired and had short term and long term memory problems. A "Resident Concern Form" dated 11/8/10 indicated a concern of lost money, "$60 missing over last several weeks." This incident was investigated and family notified. A "Resident Concern Form" dated 5/10/11 at 4:40 p.m. indicated a concern of lost property: "4 - $100 bills, check for $100." This incident was investigated and family notified. During an interview on 5/27/11 at 3:18 p.m., the Executive Director indicated these incidents had not been reported to the Indiana State Department of Health. She said: "If I knew for sure the money was missing I would report to ISDH for misappropriation of funds. With him I'm not sure that he actually has money missing."			

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3. Resident #45's record was reviewed on 5/27/11 at 8:55 a.m. The record indicated Resident #45 was admitted with diagnoses that included, but were not limited to, anemia, degenerative joint disease, osteoarthritis, and insomnia.

A quarterly MDS assessment dated 3/24/11 indicated Resident #45 had no cognitive impairment and no long or short term memory problems.

A "Resident Concern Form" dated 11/8/10 at 11:01 (no a.m. or p.m. on the form) was provided by the Social Services Director on 5/27/11 at 10:15 a.m. and indicated a concern of lost property, a Samsung LCD 18 inch TV. The investigation included: "Interviewed all staff - reports they recall seeing it but assumed fam. took hm (home) when brought in her 52" TV. Nurse [name of nurse] reported [Resident] mentioned giving it to a friend at [another facility]. TC (telephone call) made to [another facility]. Friend - [name] did not have TV per TC (telephone) call. Searched all res[ident's] rooms storage of items for facility - not located. Spoke [with] res & fam[ily]. They are satisfied [with] investigation. No resolution."

A "Resident Concern Form" dated

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	12/30/10 at 11:00 a.m. indicated a concern of lost property; "$45 worth of #5 bills in an envelop in a shoe box on her bed - was out of Rm for 1 - 1 1/2 hr 12/29 afternoon." This incident was investigated and police and family were notified. During an interview on 5/27/11 at 10:15 a.m., the Social Services Director indicated these two incidents had not been reported to the Indiana State Department of Health. 3.1-28(a)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure adherence in following the physician's current orders for care in regard to: 1. omitting a medication to be given on a weekly basis for 1 of 2 supplemental	F0282	F282 Services by qualified persons/per care plan1. On 5-26-2011 The Director of Health Services or designee reviewed medical records for residents #9 & #30. a. Resident #9: medication error report was completed for 5-17-11 on	07/01/2011

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	sample residents reviewed for medication accuracy. (Resident #9) 2. providing an inaccurate dosage of medication for 1 of 2 supplemental residents reviewed for medication accuracy. (Resident #30) Findings include: 1. During the medication pass observation on 5-24-11 at 7:25 a.m., LPN #1 was observed providing the morning medications to Resident #9. After the medication observation was completed, a medication reconciliation was conducted to verify what medications were given in comparison to what medications had been ordered by the physician. The physician orders indicated Resident #9 was to receive Vitamin D-2 50,000 units once weekly by mouth. On the Medication Administration Record (MAR) this medication was identified to be given each Tuesday upon rising. This medication was not identified as being administered on 5-17-11 as the date had been "boxed in" to identify which date to give the weekly medication; however, the box was empty with no one's initials placed within the box to indicate it had been administered. A "Medication Error Report," dated 5-24-11 indicated Vitamin D-2 50,000 units 1 capsule orally once weekly on Tuesdays had been omitted on		5-24-11. Resident received proper dose of medication on 5-24-11. MD and family notified of Medication error. b. Resident #30: medication error report was completed, MD and family notified. New label with correct dosage was placed on medication on 5-25-11.2. Director of Health Services or designee will compare all MAR's with original MD orders on all residents by July 1, 2011.3. Director of Health Servies or designee will re-inservice all nurses to include LPN #1, #2 & QMA's on medication policy with emphasis on the five rights of medication pass to minimize error by July 1, 2011.4. Ten MAR's per week will be compared with physician orders to assure medications received as ordered. Audits will continue until 100% compliance is reached times three consecutive months. All results will be reviewed by QA committee and need for further auditing will be determined by committee.	

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	5-17-2011. 2. During the medication pass observation on 5-25-11 at 11:35 a.m., LPN #2 was observed providing the noon medications to Resident #30. LPN #2 was observed administering 5 milliliters of Xyloxin liquid to Resident #30 prior to her meal. After the medication observation was completed, a medication reconciliation was conducted to verify what medications were given in comparison to what medications had been ordered by the physician. The physician orders indicated on 5-19-11 at 10:55 a.m. a clarification order to increase the Xyloxin to 2 tsp. (teaspoons or 10 milliliters) by mouth four times daily 5 minutes before meals and at bedtime. A previous order, dated 5-17-11 at 10:45 a.m. for Xyloxin indicated to give 5 milliliters (ml) orally three times daily before meals was noted in the physician's order portion of the clinical record. The medication label on the bottle of medication indicated to administer Xyloxin Oral Suspension 5 ml four times daily before meals and at bedtime. In an interview with LPN #2 on 5-26-11 at 8:01 a.m., LPN #2 indicated she had given 5 ml of Xyloxin to Resident #30			

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	during the medication observation the previous day. A policy entitled, "Guidelines for Medication Error Reporting," with an effective date of 11-10 was provided on 5-26-11 at 3:50 p.m. by the Director of Health Services. This policy indicated to take whatever immediate action to protect the resident, to notify the physician and family of the event, to document the error and to monitor the resident for untoward reactions. A policy entitled, "Oral Medication Administration," with an effective date of 2-1-10 was provided on 5-25-11 at 9:45 a.m. by the Director of Health Services. Under the heading of procedures, section B-1 indicated to pour the correct amount into medication cup. 3.1-35(g)(2)			
F0387 SS=D	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on interview and record review, the	F0387	F387 Frequency and Timeliness	07/01/2011

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	facility failed to ensure physician visits were conducted every 60 days in 1 of 3 records reviewed for timeliness of physician visits in a sample of 12. (Resident #33) Findings include: Resident #33's clinical record was reviewed on 5-24-11 at 2:15 p.m. Her diagnoses included, but were not limited to, Alzheimer's disease, dementia, hypertension (high blood pressure), severe arthritis, cerebrovascular accident (stroke), congestive heart failure (fluid build-up around the heart associated with significant heart problems), aspiration pneumonia (March 2011), and a history of falls. The physician progress notes indicated the physician visited on 8-20-10 and not again until 1-6-11. This resulted in 108 days between physician visits. In interview with the Director of Health Services (DHS) on 5-25-11 at 12:40 p.m., she indicated she could not find any record of a physician's visit for October 2010 [date the next physician's visit was due.] The DHS indicated the physician is normally "like clockwork" in regards to timely physician visits and she did not know why this happened.		of Physcian Visits1. Physician visited and completed assessment on resident #33 on 1-6-11. 2. Director of Health Services or Designee will review all residents medical record to assure timely MD visit as per policy by July 1, 2011.3. Director of Health Services or Designee will re-inservice physcian and medical records nurse in regards to policy of physcian visits by July 1, 2011.4. Medical Records/Designee will track physcian visits to assure timely as per policy. This audit is ongoing.	

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	3.1-22(d)(1) 3.1-22(d)(2)			
F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure 2 residents received correctly administered physician ordered medications during the medication pass observation in which 9 residents were observed for correct medication administration. (Resident #9 and #30) Findings include: 1. During the medication pass observation on 5-24-11 at 7:25 a.m., LPN	F0425	F425 Pharmaceutical Service-Accurate Procedures, RPH.1. On May 26, 2011, Director of Health Services or Designee reviewed medical record for residents #9 and #30. a. Resident #9 Medication error report was completed for 5-17-2011 on 5-24-2011. Resident received the proper dose of medicaton on 5-24-11. MD and family notified of medication error. b. Resident #30 Medication error report was completed. MD and family notified. New label with correct dosage was placed on	07/01/2011

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	#1 was observed providing the morning medications to Resident #9. After the medication observation was completed, a medication reconciliation was conducted to verify what medications were given in comparison to what medications had been ordered by the physician. The physician orders indicated Resident #9 was to receive Vitamin D-2 50,000 units once weekly by mouth. On the Medication Administration Record (MAR) this medication was identified to be given each Tuesday upon rising. This medication was not identified as being administered on 5-17-11 as the date had been "boxed in" to identify which date to give the weekly medication; however, no one's initials were placed within the box to indicate it had been administered. A "Medication Error Report," dated 5-24-11 indicated Vitamin D-2 50,000 units 1 capsule orally once weekly on Tuesdays had been omitted on 5-17-2011. 2. During the medication pass observation on 5-25-11 at 11:35 a.m., LPN #2 was observed providing the noon medications to Resident #30. LPN #2 was observed administering 5 milliliters of Xyloxin liquid to Resident #30 prior to her meal. After the medication observation was completed, a medication reconciliation		medication on 5-25-11.2. Director of Health Services or Designee will compare all MAR's with original MD orders on all residents by July 1, 2011.3. Director of Health Services or Designee will re-inservice all nurses to include LPN#1, #2 and QMA's on medication policy with emphasis on the five rights of medication pass to minimize error by July 1, 2011.4. Ten MAR's per week will be compared with physician orders to assure medications received as ordered. Audits will continue until 100% compliance is reached times three consecutive months. All results will be reviewed by QA committtee and need for further auditing will be determined by the committee.	

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	was conducted to verify what medications were given in comparison to what medications had been ordered by the physician. The physician orders indicated on 5-19-11 at 10:55 a.m. a clarification order to increase the Xyloxin to 2 tsp. (teaspoons or 10 milliliters) by mouth four times daily 5 minutes before meals and at bedtime. A previous order, dated 5-17-11 at 10:45 a.m. for Xyloxin indicated to give 5 milliliters (ml) orally three times daily before meals was noted in the physician's order portion of the clinical record. The medication label on the bottle of medication indicated to administer Xyloxin Oral Suspension 5 ml four times daily before meals and at bedtime. In an interview with LPN #2 on 5-26-11 at 8:01 a.m., LPN #2 indicated she had given 5 ml of Xyloxin to Resident #30 during the medication observation the previous day. A policy entitled, "Guidelines for Medication Error Reporting," with an effective date of 11-10 was provided on 5-26-11 at 3:50 p.m. by the Director of Health Services. This policy indicated to take whatever immediate action to protect the resident, to notify the physician and family of the event, to document the error and to monitor the resident for untoward			

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	reactions. A policy entitled, "Oral Medication Administration," with an effective date of 2-1-10 was provided on 5-25-11 at 9:45 a.m. by the Director of Health Services. Under the heading of procedures, section B-1 indicated to pour the correct amount into medication cup. 3.1-25(b)(3) 3.1-25(b)(9)			
R0000				
	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R0000	R117 Personnel1. Staff; CNA's #1, 2, 3, 4, 7, LPN #5 QMA #6 and the Activity Director will be trained on First Aid by July 1, 2011.2. all other staff that are scheduled on Residental Files were reviewed to assure current first aid by the Director of Health Services/Designee by July 1, 2011.3. All Depart Leaders to Include Payroll were inserviced on the policy on First aid training by Director of Health Services/Designee by July 1, 2011.4. Director of Health Services or Designee will monitor all employee files that work Residental to assure continuing education in first aid. These audits will be ongoing. All results will be reviewed by the QA committee to assure compliance.	

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R0117	(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. This State Residential finding was not met as evidenced by: Based on record review and interview the facility failed to ensure staff had first aid training for 8 of 8 employee records reviewed. This deficient practice had the potential to affect 32 residential residents. (CNA's #1, 2, 3, 4, 7, LPN #5, QMA #6, and the Activity Director) Findings included:	R0117	R117 Personnel1. Staff; CNA's #1, 2, 3, 4, 7, LPN #5 QMA #6 and the Activity Director will be trained on First Aid by July 1, 2011.2. all other staff that are scheduled on Residental Files were reviewed to assure current first aid by the Director of Health Services/Designee by July 1, 2011.3. All Depart Leaders to Include Payroll were inserviced on the policy on First aid training by Director of Health Services/Designee by July 1, 2011.4. Director of Health Services or Designee will monitor all employee files that work	07/01/2011

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	A policy and procedure for "Emergency Care", with a last review date of 12/29/10, was provided by Employee # 9/medical records on 5/27/11 at 5:34 p.m. This policy included, but was not limited to, "Emergency Care Purpose: To assure adequate response to resident emergencies. Policy statement: Residents will receive appropriate emergency care...At least one on-duty staff will be trained in first aid and CPR (cardiopulmonary resuscitation) for early management of problems...." On 5/23/11 at 4:03 p.m., the Payroll Coordinator provided a list of all current employees, including 74 nursing staff. The employee record review was conducted on 5/27/11 at 10:30 a.m. The employee record review indicated 8 of 8 of the staff were not certified in first aid; CNA's #1, 2, 3, 4, 7, LPN #5, QMA #6, and the Activity Director. During an interview on 5/27/11 at 2:35 p.m., the Payroll Coordinator, who provided the employee records, indicated: "This is the most current information we have for CPR and first aid. Yes, we knew a few of them were expired. Several employees just went through the CPR training, but we don't have the cards back.		Residental to assure continuing education in first aid. These audits will be ongoing. All results will be reviewed by the QA committee to assure compliance	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	It didn't include the first aid training."			
R0298	(2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and observation the facility failed to ensure the pharmacist regimen review was completed for residents at least every 60 days. This affected 3 residents in the residential sample of 7 reviewed for pharmacy regimen review. (Resident # 52, # 55, and # 61) Findings included: 1. On 5/25/11 at 9:45 a.m., the clinical	R0298	R298 Phamaceutical Services1. Resients #61, #52, & #55 received pharmaceutical review on 6-4-2011.2. all Residential residents received pharmaceutical review on 6-4-11.3. Director of Health Services or Designee will re-inservice all nurses on pharmaceutical services policy with an emphasis on timely review.4. Director of Health Services or Designee will review five clinical records every week to assure timely pharmacy review until 100% compliance times	06/04/2011

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	155742	A. BUILDING 00 B. WING	05/27/2011

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	record review for Resident # 55, indicated the resident was admitted with, but not limited to the following diagnoses: hypertension, diabetes mellitus, atrial fibrillation, hyperlipidemia, and coronary artery bypass surgery in January 2011. The facility staff administers all of the resident's medications. Review of the Pharmacy Consulting drug regimen review notes for Resident # 55, on 5/26/11 at 9:15 a.m., indicated pharmacy reviews on 6/5/10 and 8/31/10, resulting in 86 days between reviews. Review of physician history and physical dated 1/14/11, indicated resident # 55 is in rehab for recovery from surgery. Pharmacist regimen review note between 12/19/10 and 5/10/11 indicated, "-to HC unit p [after] hosp [hospitalization]", no date on this note. During an interview with Resident # 55, on 5/27/11 at 9:12 a.m., the resident indicated that he came back from the hospital and spent 6 weeks on the healthcare side for therapy and then returned to his assisted living apartment. The last pharmacy regimen review was on 5/11/11. 2. On 5/26/11 at 9:15 a.m., the clinical record review for Resident # 61, indicated the resident was admitted with, but not		three months. All results will be reviewed by the QA committee to assure compliance.	

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	limited to the following diagnoses: Diabetes mellitus type II, hypertension, macrolytic anemia, gastroesophageal reflux disease, and osteoporosis. Facility staff administers all of resident's medications. Review of the Pharmacy Consulting drug regimen review notes for Resident # 61, on 5/27/11 at 5:20 p.m., indicated pharmacy reviews completed on 6/5/10 and 8/31/10, resulting in 86 days between reviews. The pharmacy regimen review notes indicated reviews completed on 12/19/10 and 2/28/11, resulting in 69 days between reviews. 3. On 5/26/11 at 11:30 a.m., the clinical record review for Resident # 52, indicated the resident was admitted with, but not limited to the following diagnoses: Gastroesophageal reflux, hypertension, atypical chest pain, diastolic dysfunction, osteoarthritis, and chronic obstructive pulmonary disease. Facility staff administers resident's medications except her nebulizer medications, which she has a self-administration evaluation for. Review of the Pharmacy Consulting drug regimen review notes for Resident # 52, on 5/27/11 at 5:25 p.m., indicated pharmacy reviews completed on 6/5/10 and 8/31/10, resulting in 86 days between			

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	reviews. The pharmacy regimen review notes completed on 12/19/10 and 2/28/11, resulting in 69 days between reviews. On 5/27/11 at 5:35 p.m. a policy entitled, "Assisted Living A-105 Policy"was reviewed. The policy indicated, "Policy Title: Medication and Treatment Records", "Policy Statement: ....A consultant pharmacist will review the drug regimen every 60 days if staff administers medication."			
R0410	(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to complete TB	R0410	R410 Infection Control1. Residents #73, #49 & #61 have current TB Mantoux by July 1,	07/01/2011

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	(tuberculosis) Mantoux testing at the required times. This affected 3 of 7 residents reviewed for TB Mantoux testing in the residential sample of 7. (Resident # 49, Resident # 61, and Resident # 73) Findings include: 1. On 5/24/11 at 11:15 a.m., review of the clinical record of Resident # 73, indicated the resident was admitted with, but not limited to the following diagnoses: Chronic obstructive pulmonary disease, rheumatoid arthritis, hypertension, diabetes type II, Alzheimer's disease with disturbance of mood, and depression. Review of a Radiology report provided by executive director on 5/25/11 at 11:23 a.m., indicated Resident # 73 had a "TB skin test L [left] forearm on 6/25/10" and "6/28/10 PPD 0 mm [millimeters] induration". The 2nd step TB Mantoux test was not found in the clinical record. During an interview with the DHS [Director of Health Services] on 5/25/11 at 10:30 a.m., she stated,"we inadvertently missed the second step TB Mantoux on (name of resident)." 2. On 5/25/11 at 11:30 a.m., review of the clinical record of Resident # 49, indicated the resident was admitted with, but not		2011.2. Director of Health Services or Designee will monitor all medical records for current TB Mantoux and second step (where applicable) by July 1, 2011. 3. Director of Health Services or Designee will inservice all nurses by July 1, 2011 on the TB policy.4. Director of Health Services or Designee will monitor all residents medical records ongoing for compliance.	

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	limited to the following diagnoses: Congestive heart failure, renal insufficiency, hypertension, coronary artery disease, and depression. Review of Resident # 49's immunization record and tuberculosis summary record, both indicated that the resident had an initial TB Mantoux test on 1/2/10 in the RFA [right forearm] and read on 1/4/10 with 0 mm induration, a 2nd step TB Mantoux test was completed on 1/16/10 in the LFA [left forearm] and read on 1/18/10 with 0 mm induration. The next TB Mantoux test given was documented as 2/22/11 in the RFA, but no documentation as to the results in millimeters of induration or nurse signature. The annual TB Mantoux was due in January 2011. 3. On 5/26/11 at 9:15 a.m., review of the clinical record of Resident # 61, indicated the resident was admitted with, but not limited to the following diagnoses: Diabetes mellitus type II, hypertension, macrolytic anemia, gastroesophageal reflux disease, and osteoporosis. Review of Resident # 61's immunization record and tuberculosis summary record, indicated the resident had an initial TB Mantoux skin test on 1/3/10 in the RFA [right forearm] and there was 0 mm			

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	induration on 1/5/10. The 2nd step TB Mantoux test was completed on 1/18/10 in the RFA with 0 mm induration on 1/20/10. The resident's annual TB Mantoux test had not been given at the time of this review. The annual TB Mantoux due in January 2011 according to the resident's original admission date of 1/4/10.			